Goals

- **The Back Story:** Success starts with understanding the nursing home world and its evolving patient population
- **Being in the Know:** Learn how the key regulatory changes transform end of life care for nursing home residents
- **Becoming the "Go To" Hospice:** Turn your knowledge into action by identifying key do's and don'ts in working with nursing homes
Preface

• This presentation is meant to provide a general overview of considerations in partnering with nursing homes
• This presentation does not constitute legal advice, and is not intended to take the place of legal advice

The Back Story: New Obligations for an Aging Population
Success Starts with Understanding

- The realities of nursing homes are different than those of hospices
- Unsuccessful partnerships often a by-product of a failure to understand the nursing home world and its unique challenges

Key Differences Between the Nursing Home and Hospice Worlds

<table>
<thead>
<tr>
<th>Nursing Homes</th>
<th>Hospices</th>
</tr>
</thead>
<tbody>
<tr>
<td>About 60% Medicaid - Medicaid rate significantly lower than Medicare</td>
<td>About 84% Medicare (about 5% Medicaid) - Medicare and Medicaid rates are the same</td>
</tr>
<tr>
<td>Annual surveys, as well as complaint surveys</td>
<td>Typically only surveyed every few years, as well as complaint surveys</td>
</tr>
<tr>
<td>Can be assessed fines of up to $10,000 per day or per incident for federal survey citations</td>
<td>No monetary penalties for federal survey citations</td>
</tr>
</tbody>
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Key Differences Between the Nursing Home and Hospice Worlds

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<td>CMS interpretive guidelines (Appendix PP) are over 670 pages long</td>
<td>CMS interpretive guidelines (Appendix M) are only 183 pages long</td>
</tr>
<tr>
<td>Emphasis on maintaining a patient's highest level of functioning</td>
<td>Emphasis on quality of life and patient's wishes</td>
</tr>
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</table>

The New Normal: An Aging Nursing Home Population

- Nursing home discharges due to death are estimated to account for 1/4 to 1/3 of all yearly discharges
- Estimated that by 2030, 1/2 of the 3 million people projected to be living in a nursing home will die there
- Number of nursing home residents aged 85 and older could increase by 300% by 2030

The New Normal: Increase in Utilization of Hospice Benefit

- Between 2000 and 2011, Medicare expenditures on hospice more than quadrupled to approximately $13.8 billion
- In 2011, 45.2% of Medicare beneficiaries who died used hospice, up from 22.9% in 2000
- Approximately 18% of hospice patients die in a nursing home

Sources: National Hospice and Palliative Care, Newsline, Hospice Facts and Figures: A Six Year Snapshot (March 2013); MedPAC Report to Congress, Chapter 12, Hospice Services (March 2013)

The New Normal: Increased Scrutiny of Facility/Hospice Relationships

- While facility/hospice relationships have long been an area of review by the OIG, increased utilization of hospice by facility residents and more complex relationships have led to additional scrutiny
  - 1997 OIG Report "Hospice Patients in Nursing Homes"
  - 1998 Special Fraud Alert "Fraud and Abuse in Nursing Home Relationships with Hospices"
  - 2009 MedPAC Report
  - 2011 OIG Report "Medicare Hospices that Focus on Nursing Facility Residents"
  - 2013 OIG Work Plan
The New Normal: Facility/Hospice Risk Areas

- Risk areas identified by the OIG include:
  - Providing hospice staff to facility to perform duties that otherwise would be performed by nursing home staff
  - Offering goods for free or below market value
  - Paying amounts to nursing homes for services considered to be covered by the Medicaid room and board rate
  - “Trolling” for patients
  - Patients with unpredictable disease trajectories or long lengths of stay
  - High pressure marketing of hospice care to ineligible beneficiaries

The New Normal: Focused Scrutiny

- 2013 OIG Work Plan focuses on hospices with a high percentage of their beneficiaries in facilities
  - Will be reviewing:
    - Hospice marketing practices and marketing materials in facilities
      - Anecdotal evidence of aggressive marketing to facility patients
    - Hospice financial relationships with facilities
      - MedPAC noted potential for inappropriate compensation between facilities and hospices
    - Hospice patient admissions in facilities
      - 2009 OIG report that 82% of hospice patients in facilities did not meet coverage requirements
The New Normal: Impending Changes in Hospice Reimbursement

- Given the new normal, CMS is exploring changes to hospice reimbursement for all patients
  - U-shaped curve
  - "Site of Service" adjustment for hospice patients in nursing facilities
  - Rebasing the routine home care rate (adjustment based on current cost data)
  - Short stay add on payments

The New Normal: New Obligations for Facilities

- Given the new normal, CMS issued 3 new categories of obligations for facilities related to end of life care
- New obligations signal philosophical change and mainstream recognition that patients' wishes at end of life are primary goal
- Facility surveyors likely to focus on these new obligations
New Obligations for Facilities:
1. Hospice Contract Requirements

- June 2013: New regulations for facilities related to hospice services at 42 C.F.R. § 483.75(t)
  - Sets forth legal requirements for facilities that choose to contract with a hospice
  - Reflects hospice regulations (418.112) for facility contracts

2. Advance Care Planning

- November 2012: Revised guidelines at F-155 related to advance directives
  - Requires policies and procedures regarding advance directives
  - Creates affirmative obligations for advance care planning and focus on resident care goals
New Obligations for Facilities:
3. End of Life Care Planning

- November 2012: Revised guidelines at F-309 related to end of life care planning
  - Recognizes different care planning needs for residents at the end of life
  - Requires regular assessment and monitoring of residents approaching the end of life
  - Creates affirmative obligations for end of life care standards focused on resident wishes
1. Contracting Requirements with Hospices

- 42 C.F.R. § 483.75(t) effective August 26, 2013
- Key points:
  - It's a facility's choice: No requirement that a facility contract with a hospice
  - But, if no contract, facility must transfer resident
  - Sets forth specific requirements for written agreement if facility chooses to work with a hospice
  - Includes general obligations for facilities that contract with a hospice

Contracting with Hospices: Requirements for the Written Agreement

- Note that only some of the provisions of 483.75(t) must be addressed in the written agreement
- Remaining provisions are general obligations of the facility
- See handout chart to visualize written vs. non-written requirements
Contracting with Hospices:
Revising Current Contract

• CMS indicated in commentary that current hospice-facility contracts should not need to be revised as the new facility requirements are "equivalent to" those in the hospice regulations
  - Note difference between notification of alleged violations (24 hours vs. immediately)
  - Consideration: Include general obligations in the written agreement?

Contracting with Hospices:
Written Agreement Requirements

• Written requirements found in 42 C.F.R. § 483.75(t)(2)(ii)
• Some key written requirements that must be included:
  - The hospice's responsibility for determining the hospice plan of care
  - A communication process, including how the communication will be documented between the facility and hospice
  - An agreement that it is the facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care is appropriate
  - A provision that the facility must report all alleged violations of abuse, neglect, and misappropriation to hospice immediately
Contracting with Hospices: Key General Obligations

- Ensure the hospice services meet applicable professional standards and principles
  - Indicates some level of facility responsibility for contracting with a quality hospice provider
  - Consideration: How can you show you are a quality provider?
- Designate a member of the facility's interdisciplinary team to coordinate care with the hospice representative
  - Specific obligations of facility IDG member ranging from communicating with hospice and physicians to obtaining patient information (hospice plan of care, election, certifications, etc.)
  - Must have clinical background, but not required to be nurse
  - Consideration: Facilities may choose different types of people to fulfill this role - how to build this key relationship for hospice?

Contracting with Hospices: Key General Obligations (cont.)

- Ensure that each resident's written plan of care includes the most recent hospice plan of care and a description of services furnished by the facility
  - Considerations:
    - What are your methods for communicating care plan, both verbally and in writing or electronically?
    - Do your methods of communication/coordination work for the facility?
    - One size doesn't fit all
Being in the Know:

2. Advance Directives and Care Planning
   - F-155 effective November 30, 2012
   - Key points:
     - Advance care planning begins at admission and continues throughout stay
     - Critical to identify correct decision-maker (resident, legal representative)
     - Reflects ongoing emphasis of "resident centered" care

Advance Directives and Care Planning: Admission
   - Facilities must:
     - Determine whether resident has executed advance directive (e.g., living will, directive to the physician, health care power of attorney, DNR)
     - Provide information about advance directives
   - Facilities can't condition care on execution of advance directive
Advance Directives and Care Planning: Ongoing

- Facilities must:
  - Document resident’s choices regarding future health care regardless of whether or not there is an advance directive
  - Continue to assess resident for capacity and decline or improvement
  - Identify, clarify, and periodically review existing care instructions and whether resident wishes to change or continue instructions
- Facilities can’t transfer/discharge solely based on refusal, unless resident otherwise meets conditions for discharge
- Considerations: How is hospice assessing and documenting resident’s wishes and ongoing advance care planning?

F-155: Right to Refuse Treatment

- F-155 also addresses the resident’s right to accept or refuse treatment
  - Assess patient for capacity
  - Document refusal
  - Offer other pertinent treatment
  - Continue to provide all other appropriate services
- Considerations:
  - How is hospice reviewing and documenting refusal of services?
  - How is refusal and other care being coordinated and assessed?
3. End of Life Care Planning Guidelines

- **F-309 effective November 30, 2012**
- **Key points:**
  - Care planning should be appropriate given the resident's prognosis and goals of care
  - Residents approaching end of life need to be regularly assessed and monitored for changes in condition and necessary interventions
  - Relaxing "highest practicable" functioning standard for end of life residents
  - Reflects emphasis on "resident centered" care

**F-309 End of Life Care Planning Guidelines: Overview**

- Facilities must:
  - Discuss advance care planning and end of life care goals
  - Advise about palliative care options, including hospice
  - Provide services and support that accommodate the resident's care goals
F-309: Acknowledging Resident Care Goals

• Previous tension between resident care goals at end of life and "highest practicable well-being"
• F-309 acknowledges that resident quality of life is critical at the end of life, and "highest practicable well-being" should be focused on comfort and relief of symptoms

F-309: Examples of Flexibility for End of Life Care

• F-309 recognizes specific instances where care planning may be different for residents at the end of life, for example:
  - ADLs: Appropriate adjustments to frequency of turning, getting out of bed, and dressing
  - Skin integrity: Prevention/treatment measures may cause more discomfort than benefit
  - Medical treatment: Reduce frequency of tests and monitoring, focus on symptom management
F-309: Examples of Flexibility for End of Life Care (cont.)

- Medication/Drugs: Consider resident's desired level of alertness and palliative medications for terminal restlessness.
- Nutrition and Hydration: Frequency of weight measurements, desired food and fluids.
- Activities: Appropriate types of activities, include family and friends in activities.
- Psychosocial Needs: Expand visiting hours, provide desired privacy, give information on bereavement services.

Becoming the "Go To" Hospice: Keys to Avoiding Pitfalls and What Works In A Good Partnership.
Avoiding "Pitfalls"

- Hospices (and facilities) need to understand the limits to avoid federal anti-kickback ("AKS") concerns
  - AKS is a criminal statute
  - Prohibits offering, soliciting, paying, or receiving "remuneration" for referrals
  - "Remuneration" is broadly defined – anything of value, directly or indirectly, overtly or covertly, in cash or in kind
  - Both parties are equally liable
- States often have similar anti-kickback laws

Avoiding "Pitfalls" (cont.)

- New end of life care guidance could create increased risk:
  - Pressure to take over some of the facility's responsibilities
    - End of life care discussions
    - Care planning for pre-hospice patients
    - Coverage of items/services not medically necessary
  - Pressure for free end of life care training programs/continuing education for credit
What To Do When You Get Home

- Ask why you would or would not provide NH care
- Ask why your staff would or would not want to provide facility care
- Know that it does take a lot of time to do it right, to decrease risk, to improve quality of care
- Make a purposeful decision about caring for NH patients

Quality of Life Issues
GAO Study 1999-2000

- Hospice Patients vs. other NH patients:
  - Better pain assessment and treatment – 2 times more likely to get narcotics for daily pain
  - Less likely to be hospitalized
  - More likely to have dyspnea treated
  - More likely to have depression/anxiety treated
  - Less likely to be restrained, receive tube or parenteral feedings, IM or IV Meds, therapy
  - Reference at end of slides
Compliance Checklist

• Contract review- are you compliant
• Analysis of LOS, frequency of services, types of services = to those at home?
• Know responsibilities of both facility and hospice
  - Do you follow them?
  - Do you have for each facility what is included in room and board?

Compliance Checklist (cont.)

• How would you and your team know
  - Providing more care than required by the patient’s status?
  - Providing less care than required by the patient’s status?
• Assess marketing agreements and practices?
Quality of Care to Do

• Communication and documentation processes
  - Development of plan of care
  - Changes in plan of care
  - Changes in patient status
  - Additions and deletions to care
• Joint QA reviews

Quality of Care to Do (cont.)

• Standard order sets
  - Labs, weights, getting out of bed, medications, time to eat, etc.
• Audit NH patients for eligibility
• Monitor the % of patients over 210 days
• Physician documentation
Quality of Care to Do (cont.)

• Monitor the NH patients by diagnosis vs. total program by diagnosis (dementia and TD)
  - Services provided
  - Disciplines and visits
  - After hours calls
  - Key performance indicators
  - % patients discharged alive

Staff Education to Do

• For Facility
  - How to have conversations about advance directive and end of life care
  - Pain and Symptom Management
  - Personal care at end of life
  - Spiritual/ psychosocial considerations
  - Ethics
  - Etc.
Staff Education to Do (cont.)

- For Hospice staff
  - Cheat sheet for each facility
    - Who is who
    - Vendors to use - meds, dme, iv
    - Phone numbers and fax numbers
    - After hours processes
    - Preferences
    - Medical Director

Staff Education to Do (cont.)

- For Hospice Staff
  - Nursing home COPs
  - Hospice COPs related to NH patients
  - Relationship building with facility staff
Marketing Plan to Do

- Assess your plan or develop one that is compliant with the COPs
- Decide how many facilities you can provide care at well
- Know impact of possible reimbursement changes

Marketing Plan to Do (cont.)

- Evaluate marketing materials with the facility
  - Purchasing of DME, oxygen, medications, at fair market value
- Does your staff market too aggressively? Troll for patients? How do you monitor that?
Marketing Plan to Do (cont.)

• Elaborate on what makes you different
  - Dedicated team
  - Palliative care program
  - Staff education
  - Specialty programs: Cardiac, Alzheimer's, etc.
  - Dedicated and educated facility volunteers
  - Birthday cakes for patients, etc.
Building a Successful Relationship

- There is no one-size-fits-all approach
- Stay up to speed
  - Recognize ways to better collaborate given new guidance
- Understand the pressures faced by facilities and how to improve coordination
  - Be responsive
  - Communicate through facility's preferred method
  - Schedule visits to allow time for care coordination
  - Use personnel that have developed a working relationship with facility staff
- DOCUMENT, DOCUMENT, DOCUMENT
Questions?

Thanks!

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HOSPICE CONTRACTING CHECKLIST
FOR NEW LONG TERM CARE FACILITY REQUIREMENTS RELATED TO HOSPICE SERVICES

The following checklists are intended to be used with Reinhart's template Nursing Facility Services Agreement from the Hospice and Nursing Home/Assisted Living Contracting Toolkit (the "Toolkit Template Agreement") to help guide discussions with nursing facilities regarding the new long term care facility requirements related to hospice services at 42 C.F.R. § 483.75(t) (the "New LTC Facility Regulations"). Of these requirements, the provisions under 42 C.F.R. § 483.75(t)(2)(ii) must be included in the written agreement between hospices and nursing facilities. The first checklist below indicates where these written requirements are located within the Toolkit Template Agreement, and can be used to demonstrate to nursing facilities that the written requirements are addressed in your agreement. Note that if the sections referenced in the first checklist have been altered from the Toolkit Template Agreement, an addendum may be necessary to address the new requirements. The second checklist outlines the remaining obligations under 42 C.F.R. § 483.75(t), which are not specifically required to be included in written agreements, but are important for both parties to apply in practice.

1. Specific Contract Terms Required by the New LTC Facility Regulations to Be Included in a Written Agreement between a Long Term Care Facility and a Hospice

<table>
<thead>
<tr>
<th>Citation</th>
<th>Requirement</th>
<th>Section in Template Nursing Facility Services Agreement</th>
</tr>
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<tbody>
<tr>
<td>42 C.F.R. § 483.75(t)(2)(ii)</td>
<td>If hospice care is furnished in an LTC facility, the LTC facility must have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC before care is furnished to any resident. The written agreement must set out at least the following --</td>
<td>Entire written agreement</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(2)(ii)(A)</td>
<td>The services the hospice will provide.</td>
<td>1(d)</td>
</tr>
</tbody>
</table>
| 42 C.F.R. § 483.75(t)(2)(ii)(B)| The hospice's responsibilities for determining the appropriate hospice plan of care as specified in 42 C.F.R. § 418.112(d). | 2(d)(ii)  
                        |                                                                              | 3(b)(i)       |
| 42 C.F.R. § 483.75(t)(2)(ii)(C)| The services the LTC will continue to provide, based on each resident's plan of care. | 1(a)  
<pre><code>                    |                                                                              | 2(a)(i)        |
</code></pre>
<table>
<thead>
<tr>
<th><strong>42 C.F.R. § 483.75(t)(2)(ii)(D)</strong></th>
<th>A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.</th>
<th>2(d)(i)</th>
</tr>
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<tr>
<td><strong>42 C.F.R. § 483.75(t)(2)(ii)(E)</strong></td>
<td>A provision that the LTC facility immediately notifies the hospice about the following:</td>
<td>2(d)(iv)</td>
</tr>
<tr>
<td><strong>A significant change in the resident's physical, mental, social, or emotional status.</strong></td>
<td></td>
<td>2(d)(iv)</td>
</tr>
<tr>
<td><strong>Clinical complications that suggest a need to alter the plan of care.</strong></td>
<td></td>
<td>2(d)(iv)</td>
</tr>
<tr>
<td><strong>A need to transfer the resident from the facility for any condition.</strong></td>
<td></td>
<td>2(d)(iv)</td>
</tr>
<tr>
<td><strong>The resident's death.</strong></td>
<td></td>
<td>2(d)(iv)</td>
</tr>
<tr>
<td><strong>42 C.F.R. § 483.75(t)(2)(ii)(F)</strong></td>
<td>A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.</td>
<td>3(b)(i)</td>
</tr>
<tr>
<td><strong>2(d)(ii)</strong></td>
<td>2(d)(iii)</td>
<td></td>
</tr>
<tr>
<td><strong>42 C.F.R. § 483.75(t)(2)(ii)(G)</strong></td>
<td>An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.</td>
<td>2(a)(i)</td>
</tr>
<tr>
<td><strong>2(a)(ii)</strong></td>
<td>2(d)(i)</td>
<td></td>
</tr>
<tr>
<td><strong>42 C.F.R. § 483.75(t)(2)(ii)(H)</strong></td>
<td>A delineation of the hospice's responsibilities, including, but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</td>
<td>1(d)</td>
</tr>
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### Regulatory Obligations Of A Long Term Care Facility In The New LTC Facility Regulations Not Specifically Required To Be Included In A Written Agreement

<table>
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<tbody>
<tr>
<td>42 C.F.R. § 483.75(t)(2)(i)</td>
<td>If hospice care is furnished in an LTC facility, the LTC facility must ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)</td>
<td>Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following --</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(i)</td>
<td>Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(ii)</td>
<td>Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.</td>
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<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(iii)</td>
<td>Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(iv)</td>
<td>Obtaining the following information from the hospice:</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(iv)(A)</td>
<td>The most recent hospice plan of care specific to each patient.</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(iv)(C)</td>
<td>Physician certification and recertification of the terminal illness specific to each patient.</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(iv)(D)</td>
<td>Names and contact information for hospice personnel involved in hospice care of each patient.</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(iv)(E)</td>
<td>Instructions on how to access the hospice's 24-hour on-call system.</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(iv)(F)</td>
<td>Hospice medication information specific to each patient.</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(iv)(G)</td>
<td>Hospice physician and attending physician (if any) orders specific to each patient.</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(3)(v)</td>
<td>Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</td>
</tr>
<tr>
<td>42 C.F.R. § 483.75(t)(4)</td>
<td>Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at § 483.25.</td>
</tr>
</tbody>
</table>